# Cosmetic Surgery of New York, P.C.

Patient's Name: _____ Date: _____

Your Name: _____ Relationship: _____

Your family Physician: _____

Brief history of the problem or concern: _____
_____

Have you seen another physician about this problem? _____

Height: _____Weight: _____ Blood Pressure: _____/_____

Medications taken routinely, including over the counter, diet and herbal supplements
Aspirin, Motrin, Accutane, Serzone etc. _____
_____

Drug Allergies: _____
Illegal Drug Use: ___ Yes ___ No
Alcohol Use: ____ Socially ___ Daily ___ Do not use
Do you smoke now? _____ ? # Per day _____
***Smoking is hazardous to your health and wound healing and can result in skin and/or tissue loss, poor wound healing and other complications. You are advised not to smoke for at least 2 weeks before or after your surgery***.
List all previous surgeries **with dates**. Include all cosmetic surgery and injuries:_____
_____
_____

Medical History: Have you ever had, or been treated for:

[ ]None of the conditions listed below
[ ]Diabetes
[ ]Heart Attack
[ ]Heart trouble
[ ]Tumors, benign or malignant [cancer]
[ ]Low blood count, anemia, bleeding
[ ]Bleeding tendency
[ ]Mental or emotional problems
[ ]Breathing problems, short of breath
[ ]Asthma
[ ]Urinary tract or kidney disease
[ ]Fractures, scoliosis, back trouble
[ ]Pacemaker/Defibrilator
[ ]Other

[ ]Endocrine or thyroid disease
[ ]High Blood Pressure
[ ]Congenital heart disease
[ ]Stroke
[ ]Hepatitis
[ ]Arthritis
[ ]Eye or ear problems
[ ]Leukemia
[ ]Neurologic disease, epilepsy, seizures
[ ]Gastrointestinal problems
[ ]Implant of any kind

[ ]Family History of: _____

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